Abstract: Keratoacanthoma presents characteristically as a perplexing lesion due to its rapid growth and histological similarity with squamous cell carcinoma. We present a case of recurrent keratoacanthoma over dorsum of the nose in a 56 year old male. Recurrence is very rarely reported after primary excision.

Keyword: Recurrent, keratoacanthoma, squamous cell carcinoma, rare, dilemma.

INTRODUCTION:
Keratoacanthoma is a common low grade tumor arising from the pilosebaceous gland. It is a variation of squamous proliferative lesions that may spontaneously regress. It has resemblance with squamous cell carcinoma because of its rapid growing nature and histological similarity, and hence is termed low-grade squamous cell carcinoma (SCC) or a benign squamous proliferation (1). Although, it is non-invasive and doesn’t metastases, keratoacanthoma can have different clinical presentations like proliferative phase, fully developed phase, regressing/regressed phase and as a recurrent (renewal) phase(2). We describe here a case of recurrent keratoacanthoma arising at site of previously excised keratoacanthoma over dorsolateral aspect of the nose.

CASE REPORT:
A 58-year-old man presented with history of a rapidly enlarging lesion over dorsum of nose with extension over right lateral wall of nose for one month. He gave history of excision of similar lesion at the same site six months back. The previous excision biopsy report was suggestive of keratoacanthoma. Current physical examination revealed a skin-coloured nodule, 15 mm in diameter, with a large, cutaneous horn-like swelling with central keratin plug over right lateral wall of nose with underlying skin scarring (Fig. 1).

A diagnosis of keratoacanthoma was made based on the clinical features with differential diagnosis of squamous cell carcinoma in view of recurrence.

Excisional was done with 4mm margin (Figure 2) and subsequent defect was closed using a paramedian forehead flap (Figure 3).

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The histopathological features revealed features of keratoacanthoma with keratin-filled, shallow cup-shaped structures rimmed by epidermal hyperplasia forming collarettes associated with irregular infiltration of squamous nests and islands accompanied by marked inflammatory infiltrate. (Figure 4-a,b,c,d).

DISCUSSION:
Recurrence of keratoacanthoma is rare after its complete excision. Recurrent keratoacanthoma is considered to be a reactive course in its proliferative phase rather than neoplastic changes or remnants of the neoplastic cells as it has been described to develop in healing wounds following surgery or from the scars after excision of skin malignancies like basal cell carcinoma, melanoma and conventional squamous cell carcinoma. The recurrence rate of keratoacanthoma have been mentioned as 3-8% (3). The recurrences usually develop while the lesion is excised during its proliferating phase. The recurrence appearing within few weeks of biopsy represent a recrudescence of the phase of proliferation which the initial treatment did not abolish(4). But if the recurrence occur months later then the diagnosis becomes difficult and one may consider the lesion as squamous cell carcinoma (5).

As the biological behavior of keratoacanthoma is difficult to predict because of its resemblance to squamous cell carcinoma, it should be considered for surgical excision to rule out invasive squamous cell carcinoma on histopathological study.

REFERENCES: